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1115 Draft Waiver Application Comments

Submitted by PHI-Midwest (formerly Paraprofessional Healthcare Institute)

January 22, 2014

PHI (formerly Paraprofessional Healthcare Institute) respectfully submits the following comments in response to the *Illinois 1115 Draft Waiver Application* that was released on January 7, 2014.

With a Midwest office and Illinois and Michigan staff, PHI is a national non-profit policy, training, and consulting organization whose work is grounded in the premise that quality jobs for the direct-care workers leads to quality care and support for those individuals. Given PHI's mission to promote the interconnection between the direct-care workforce, quality supports and services for people who use both HCBS and facility-based services, and the delivery of long-term supports and services, the following comments will focus on the following areas detailed in the waiver application:

- Pathway #1: Transform the Health Care Delivery System, specifically, the Nursing Facility Closure and Conversion Fund
- Pathway #3: 21st Century Health Care Workforce
- Pathway #4: LTSS Infrastructure, Choice, and Coordination

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Pathway #1: Transform the Health Care Delivery System, Nursing Facility Closure and Conversion Fund

With the growth of home and community-based services, nursing facilities are tasked with transforming to meet the needs of consumers in new ways. The Nursing Facility Closure and Conversion Fund allows for a thoughtful and planned process for transitioning nursing facilities. We would recommend that staffing issues be reviewed within a facility's plans for closure or conversion. Specifically, we would ask that the Department of Health and Family Services examine how staffing levels will be impacted by a closure or conversion by documenting the number of staff that will be laid-off or added, and how a facility plans to prepare all impacted staff for such a transition to new jobs and/or employers.

Pathway #3: 21st Century Health Care Workforce

Direct-Care Workforce Projections

As in our earlier comments on the concept paper, we believe that the size, growth, and competencies of the direct-care workforce should be addressed in the development and implementation of the 1115 Waiver. We ask you to consider and include the following direct-care workforce data and projections[1] as decisions are made regarding workforce development and training investment, alongside data and information on physicians, nurses, physician's assistants, and community health workers:

- At 151,840, Illinois direct-care workforce is third-largest occupation group in Illinois.
- Direct-care workers represent 23% of the state's entire hands-on health care workforce.
- For the decade 2010-2020, personal care aides and home health aides are projected to grow by 33% and 42% respectively. These occupations are the 2nd and 4th fastest growing occupations in Illinois.

[1] PHI analysis of data from U.S. Census Bureau, U.S. Department of Labor, Current Population Survey (CPS), and Illinois Department of Employment Security. More information available at the PHI State Data Center, www.phinational.org/policy/states

Community Health Workers and Direct Care Workers

Throughout the concept paper, and now the draft waiver application itself, references are made to community health workers, and not direct-care workers. At the January 9, 2014, stakeholder meeting, HMA staff announced that direct-care workers were included with community health workers. We would point out that while community health workers are important health care workers in need of attention and resources, they do not deliver the hands-on supports and services that are the responsibility of direct-care workers.

While both community health workers and direct-care workers provide services in community-based settings, the roles and functions of these occupations are quite different. Community health workers are generally understood to be frontline public health workers with strong ties to the communities that they serve. Community health workers tasks include outreach, community education, health counseling, advocacy, and social support. Direct-care workers are also frontline health care workers, however their work involves more hands-on services and supports to assist seniors and people with physical or developmental disabilities, chronic illness, and mental illness. Tasks for direct-care workers includes assistance with activities of daily living such as bathing, dressing, eating, and instrumental activities of daily living such as housework, shopping, and transportation. Direct-care workers are increasingly working with consumers with more complex health care issues, such as Alzheimer's, chronic health conditions, and behavioral health diagnoses. Increasingly, depending on certification and setting, their work can also include more clinical tasks such as medication reminders, measuring of vital signs, and observation and reporting of changes in medical conditions. The differences between these two important parts of the health care workforce should be recognized in workforce development efforts related to this ambitious waiver.

Direct-Care Worker Wages

Though not specifically discussed in detail in the draft waiver application, we urge Illinois to establish Medicaid reimbursement methodologies that set parity in wage rates for direct-care workers across population groups and settings. Higher, more consistent wages would make these jobs more attractive and improve retention rates. Parity does not exist currently among the nine waiver programs. As a result, some direct care jobs (and populations) are more attractive than others. Additionally, reimbursement rates should be set at a level that allows employers (agencies and individuals) to pay direct-care workers a wage rate that supports the worker and a family.

Pathway #3: LTSS Infrastructure, Coordination and Choice

Combining nine HCBS waivers into one consolidated waiver structure is an ambitious and worthy goal to undertake. Increased choice and flexibility while delivering services based on individual need and preference will require a larger, competent, well-compensated direct-care workforce that can support Illinois residents regardless of condition, age, geographic area, or disability. In order to realize this goal, we strongly believe coordinating training standards for direct-care workers and setting reimbursement methodologies that incentivize good workforce practices should also be considered as this waiver is developed and implemented.

Training

Current training and competencies for IL direct-care workers providing personal care and other services in IL waivers varies widely, depending on the program and whether the services are agency-based or self-directed. Our previous comments to the Concept Paper provide greater detail on our concerns with coordinating direct-care worker training standards across multiple programs and multiple populations that are going to be integrated.

The global, coordinated HCBS waiver that is envisioned in the *1115 Draft Waiver Application* cannot be realized with fragmented standards and mechanisms for training HCBS direct-care workers. To move

forward, purposeful and strategic investment in direct-care workforce training infrastructure is needed. PHI recommends the following:

- Identifying legislative and regulatory changes that must be made to allow for competency-based HCBS direct-care worker training for all HCBS populations and settings.
- Defining core competencies and training standards across populations and settings for workers providing homemaker, personal assistant, personal support, and home health aide services.
- Core competencies and training standards for agency-based workers and consumer-directed workers should be aligned. Training standards should be set with attention to principles of consumer-direction, and crafted and supported in ways that do not delay or interfere with access to or the quality of services.
- Defining specialized competencies that allow for an advanced role for direct-care workers to meet the more complex needs of the consumers they support and be a core part of an integrated care team.
- Establishing a coordinated and efficient training system that will equip workers with the necessary skills and a portable and expandable credential.

Outcomes-Based Reimbursement

PHI is pleased to see workforce-related measures in its plans for outcomes-based reimbursement. To accurately measure staff retention, wages, benefits, and training, we encourage the State to consider collecting a minimum data set of workforce-related data. A minimum data set will allow Illinois to gather baseline data on the size, stability, and compensation of the workforce providing services under the new waiver, and analyze it over time. The CMS-sponsored National Direct Service Workforce Resource Center, has provided guidance to states on how to collect such data. Examples of how this data can inform state agencies, participants, employers/providers, MCOs (or their word for waiver agents) can be found in the five surveys PHI conducted for the Michigan Office of Services to the

Aging. For example, part-time work varied depending on the population served and the rates at which family members become DCWs for aging and ID/DD populations in consumer-directed programs are quite different.

Thank you for the opportunity to provide comments on the *1115 Draft Waiver Application*. If you have any questions about the comments provided, please contact Tameshia Bridges Mansfield, Midwest Program and Policy Manager at 312-702-2568 or tbridges@phinational.org.